TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patient Care Injury Clinic

Respondent Name
Retailers Casualty Insurance Company

MFDR Tracking Number
M4-16-0544-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has been having difficulties with the above carrier in processing these authorized services which were denied for lack of precertification."

Amount in Dispute: $1132.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor was not the treating doctor, nor were they a referral from the treating doctor … no reimbursement is owed to Requestor because they were not an authorized health care provider."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15-17, 2015	Physical Therapy	$1132.32	$303.42

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.021 sets out the requirements for entitlement to medical benefits.
3. Texas Government Code §311.016 defines the code construction process.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   For dates of service September 15 and 16, 2015:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment. Services are disallowed as not authorized.

- 18 – Exact duplicate claim/service. Duplicate charge.
  For date of service September 17, 2015:
- 18 – Exact duplicate claim/service. Duplicate charge.

Issues

1. Is the insurance carrier's reason for denial of payment for dates of service September 15 and 16, 2015 supported?
2. Is the insurance carrier's reason for denial of payment for date of service September 17, 2015 supported?
3. What is the maximum allowable reimbursement for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed dates of service September 15 and 16, 2015 with claim adjustment reason code P12 – "WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT. SERVICES ARE DISALLOWED AS NOT AUTHORIZED." Texas Labor Code §408.021 requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor." According to Texas Government Code 311.016(3) states that, unless a different construction is expressly provided, the term "'must' creates or recognizes a condition precedent." For this reason, the requestor must support that treatment was approved or recommended by the employee's treating doctor in order to be entitled to medical benefits.

   Review of the submitted information does not support that the treatment in question was approved or recommended by the employee's treating doctor. Therefore, the insurance carrier's denial reason for these dates of service is supported. Additional reimbursement cannot be recommended.

2. The insurance carrier denied disputed date of service September 17, 2015 with claim adjustment reason code 18 – "EXACT DUPLICATE CLAIM/SERVICE. DUPLICATE CHARGE." 28 Texas Administrative Code §133.307 requires that the respondent shall provide:

   (C) a paper copy of all medical bill(s) related to the dispute, submitted in accordance with this chapter if different from that originally submitted to the insurance carrier for reimbursement;
   (D) a copy of any pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor

   Review of the submitted information does not support that these services were a duplicate claim or service. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203(c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is $56.20.

   For CPT code 97112 on September 17, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.458550. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.006 is 0.482880. Per Medicare policy, when more than one unit of designated

therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The reduced PE for subsequent units is 0.241440. The malpractice RVU of 0.01 multiplied by the malpractice (MP) GPCI of 0.955 is 0.009550. The sum of the calculations for the first unit, 0.950980, is multiplied by the Division conversion factor of $56.20 for a total of $53.45. The sum of the calculations for subsequent units, 0.709540, is multiplied by the Division conversion factor of $56.20 for a total of $39.88. The total MAR for 2 units is $93.33.

For CPT code 97110 on September 17, 2015, the RVU for work of 0.45 multiplied by the GPCI for work of 1.019 is 0.458550. The PE RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.442640. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The reduced PE is 0.221320. The MP RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.019100. The sum of 0.698970 is multiplied by the Division conversion factor of $56.20 for a total of $39.28. The total MAR for 4 units is $157.12.

For CPT code 97140 on September 17, 2015, the RVU for work of 0.43 multiplied by the GPCI for work of 1.019 is 0.438170. The PE RVU of 0.40 multiplied by the PE GPCI of 1.006 is 0.402400. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The reduced PE is 0.201200. The MP RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.009550. The sum of 0.648920 is multiplied by the Division conversion factor of $56.20 for a total of $36.47. The total MAR for 1 unit is $36.47.

For CPT code G0283 on September 17, 2015, the RVU for work of 0.18 multiplied by the GPCI for work of 1.019 is 0.183420. The PE RVU of 0.20 multiplied by the PE GPCI of 1.006 is 0.201200. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The reduced PE is 0.100600. The MP RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.009550. The sum of 0.293570 is multiplied by the Division conversion factor of $56.20 for a total of $16.50. The total MAR for 1 unit is 16.50.

4. The total MAR for the disputed services is $303.42. The insurance carrier paid $0.00. A reimbursement of $303.42 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $303.42.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $303.42 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.